



**FINAL**

HCFA MARKET RESEARCH FOR BENEFICIARIES

**INCREASING MEDICARE BENEFICIARY  
KNOWLEDGE  
THROUGH IMPROVED COMMUNICATIONS:**

**SUMMARY REPORT ON THE  
RURAL MEDICARE POPULATION**

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The primary authors of this report are Jennifer Dunbar, Policy Analyst, and Steve Parente, Senior Research Director, of Project HOPE's Center for Health Affairs. The report is a synthesis of findings from three other reports prepared under HCFA's Market Research for Beneficiaries contract:

- ◆ *Increasing Medicare Beneficiary Knowledge Through Improved Communications: Inventory Research Findings for African-American, Hispanic American, Medicare/Medicaid Dual Eligible, Rural, and About-To-Enroll Beneficiaries*, written by Kenneth R. Cahill, Myra Tanamor, and Lisa Green of Barents Group; and Joan E. DaVanzo, formerly of Barents Group [Final Draft, July 1998].
- ◆ *Increasing Medicare Beneficiary Knowledge Through Improved Communications: Focus Group Research Findings for African-American, Hispanic American, Medicare/Medicaid Dual Eligible, Rural, and About-to-Enroll Beneficiaries*, written by Barbara H. Forsyth, W. Sherman Edwards, and Martha Stapleton Kudela of Westat, Inc. [Final Draft, January 1998].
- ◆ *Increasing Medicare Beneficiary Knowledge Through Improved Communications: Medicare Current Beneficiary Survey Findings*, written by Kenneth R. Cahill, Mary A. Laschober, Lisa Green, and Margaret Edder of Barents Group; Steve Parente, Laura Hodges, and Jennifer Dunbar of Project HOPE; and Joan E. DaVanzo, formerly of Barents Group [Final Draft, August 1998].

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## CHAPTER 1. SUMMARY

As part of its long-term strategic plan, the Health Care Financing Administration (HCFA) has undertaken an Agency-wide initiative to adapt its operations to improve communications with Medicare beneficiaries and with its provider partners. Helping beneficiaries to understand their choices among health care plans, providers, and treatment options and the implications of those choices on cost, quality, access and outcomes is especially important now that the Balanced Budget Act of 1997 (BBA) has expanded the health plan options available to beneficiaries. The full range of choices envisioned under BBA is not currently available in the market but an increasing number of beneficiaries will face a much more complex set of choices in the coming years. Medicare beneficiaries not only need to understand the various features of these different options in order to choose the design that best meets their needs, they also need basic knowledge about many aspects of the Medicare program.

### Research Purpose and Methods

The market research project has focused on answering the following two questions:

- ◆ **What information do beneficiaries want or need from HCFA?**
- ◆ **What are the best ways to communicate that information to them?**

Three complementary data collection approaches were employed to answer these two questions:

- ◆ An inventory of perceived information needs and effective communication strategies from a variety of organizations that work directly with Medicare beneficiaries,
- ◆ Focus groups with Medicare beneficiaries, and
- ◆ A national survey of the Medicare population—the Medicare Current Beneficiary Survey (MCBS).

Together, the three data sources can provide HCFA with an understanding of communication with beneficiaries that is broad in scope, deep in content, and representative of the elderly Medicare population. The survey of Medicare beneficiaries helps ensure that the information gathered is representative of elderly beneficiaries,<sup>1</sup> while the focus groups and inventory of organizations contribute more in-depth information than can be obtained from a large-scale survey. A description of methodologies for each of the data collection tools is contained in a separate appendix.<sup>2</sup>

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<sup>1</sup> The MCBS data used in this report apply only to Medicare beneficiaries age 65 years old or older who were not living in a short-term or long-term care facility during the first two rounds of data collection in 1997.

<sup>2</sup> See the Appendix to Cahill, et al., *Increasing Medicare Beneficiary Knowledge Through Improved Communications: Summary Report on the General Medicare Population*, Final Draft, October 1988, Health Care Financing Administration.

As part of HCFA's commitment to adapt its operations and communication strategies to better serve *all* Medicare beneficiaries, the Agency identified a diverse set of beneficiary subgroups that it believes may have special information needs regarding the Medicare program or that may require innovative communication approaches to effectively convey information to the subgroup. This report synthesizes key findings from the three data sources for one of the identified "hard to reach" beneficiary subgroups – *elderly beneficiaries who live in rural areas*. The report compares the subgroup's information needs and best communication strategies with those of the general elderly Medicare population. Additional summary reports examine the information needs and best communication strategies for African American beneficiaries, Hispanic beneficiaries, those dually eligible for Medicaid and Medicare, beneficiaries with low education or literacy levels, and vision- and hearing-impaired beneficiaries.

The definition of "rural" used to report MCBS results throughout the report is defined as counties that do not lie within a Metropolitan Statistical Area (MSA). By this definition, rural areas include counties that are contiguous to urban centers but are not part of the MSA. These counties may have characteristics more like their urban neighbors, diminishing the ability of MCBS data to detect differences between beneficiaries living in rural areas and those in urban areas. The focus group and inventory results, however, are based on a more common definition of a rural area (e.g., an area that is relatively sparsely populated and geographically separated from an urban area).

## **Key Findings and Implications for HCFA**

### Key Findings

The rural beneficiary population is similar to the general Medicare population regarding most of its socio-demographic characteristics, information needs, knowledge of the Medicare program, and preferences for sources and modes of communication. Similar to beneficiaries in general, rural beneficiaries as a group:

- ◆ Lack basic information about the Medicare program;
- ◆ May underestimate the importance of this information and do not proactively search for it;
- ◆ Want more information on the Medicare program itself, staying healthy, and out-of-pocket payment for services;
- ◆ Turn to different information sources for different specific Medicare-related topics;
- ◆ Rely on general media sources and Medicare publications for obtaining general information about the Medicare program and for keeping up with new developments;
- ◆ Demonstrated an overwhelming preference for receiving information in person, especially for answering more specific and immediate questions; and
- ◆ Prefer brochures for ease in reviewing information and accessing information when needed, particularly for information on broad topics that may not require immediate answers.

However, rural beneficiaries as a group differ in some ways from beneficiaries in general. Compared with the general Medicare population, rural beneficiaries:

- ◆ Are slightly more likely to live alone, especially among the oldest beneficiaries (85 years and older);
- ◆ Are less likely to belong to a minority group;
- ◆ More frequently have low incomes (\$15,000 or less) and education levels (only completed 8<sup>th</sup> grade or less);
- ◆ Appear to have a greater lack of understanding about how Medicare HMOs operate;
- ◆ Rely to a much greater extent on health care providers for Medicare information;
- ◆ Trust the information received from the media and supplemental insurers less, and ranked family and friends much lower for amount of information received; and
- ◆ Have moderately less access to some newer forms of communication technologies.

### Implications for HCFA

These key findings hold several implications for designing effective communication strategies for the diverse rural communities across the United States:

- ◆ Because rural beneficiaries are similar to the general Medicare population in terms of most information needs and communication preferences, HCFA can often reach these beneficiaries using the same messages, sources, and formats as used for the general Medicare population.
- ◆ However, due to the considerable heterogeneity among rural areas, HCFA should accommodate flexibility in message content, format, sources, and communication modes to effectively reach all rural beneficiaries (as it should for beneficiaries in general). For example, inventory results suggest using local and national media in conjunction with some form of interpersonal contact to maximize the likelihood that beneficiaries living in more isolated rural communities receive and understand HCFA's messages.
- ◆ HCFA should partner with rural providers to disseminate information to rural beneficiaries. It should also consider expanding the network of healthcare "providers" who serve as information intermediaries to include rural health clinics staffed by mid-level providers (e.g., nurse practitioners and physician assistants), school-based health centers, mobile mammography units, and other non-physician providers.
- ◆ Rural providers can be an important source of a variety of information for rural beneficiaries, including details about how HMOs operate. As HMOs enter rural areas, rural beneficiaries need even more information about their structure, advantages and disadvantages, and differences from fee-for-service delivery systems than beneficiaries in urban areas who may have more familiarity with HMOs. HMOs themselves may also be able to provide some of this education to rural beneficiaries as partners with HCFA.
- ◆ A communication strategy for reaching rural Medicare beneficiaries should be characterized by heavy reliance on partnering with local social service organizations, community health centers, and other community-based organizations that have served rural elderly over time. Local organizations can provide the one-on-one assistance important to rural beneficiaries for understanding the Medicare program.

## **Organization of Report**

This report is organized into four additional chapters:

- ◆ A profile of rural Medicare beneficiaries, with their characteristics compared with the general elderly Medicare population;
- ◆ A summary of rural beneficiaries' information needs;
- ◆ A discussion of information sources preferred by rural beneficiaries; and
- ◆ A summary of communication modes preferred by rural beneficiaries.

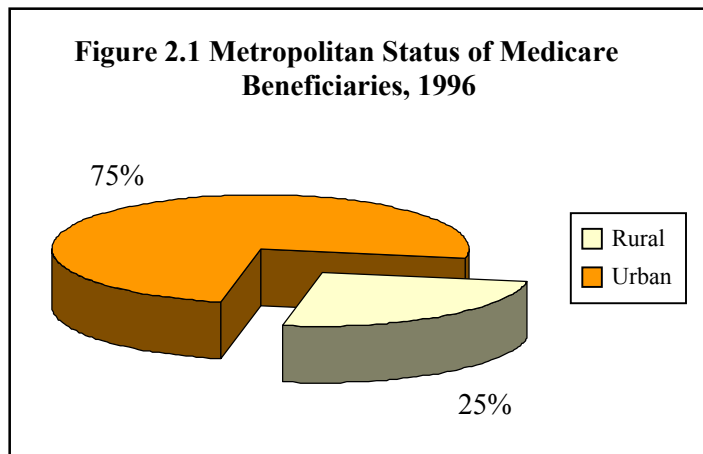
HCFA has already begun many outreach projects designed to target rural audiences. These activities provide a foundation on which to build a coordinated communication strategy that is consistent with local efforts, that leverages local resources, and makes use of advances in communication technology and information management capabilities. This report is designed to help HCFA refine, as well as expand, its activities in directions that will increase the effectiveness of its communications with beneficiaries who live in rural communities.

## CHAPTER 2. PROFILE OF RURAL MEDICARE BENEFICIARIES

The summary report on the general Medicare population emphasized that Medicare beneficiaries want information that is timely, relevant, and presented in a way that is easily comprehended and within the context of their individual circumstances. In addition, the inventory research found that beneficiaries in rural areas are exposed to many of the same messages as the rest of the Medicare population. However, the effect of these messages on rural beneficiaries is likely to be minimal unless reinforced by more specific messages perceived as personally relevant to this unique group of beneficiaries. This section provides a profile of rural beneficiaries that will aid HCFA in designing communication strategies that can more effectively target this population.

**Even for rural beneficiaries, a “one size” communication approach will not fit all beneficiaries.** Rural communities exhibit considerable diversity from region to region across the United States. For example, rural areas contiguous to urban centers often have relatively high population densities and well-developed social service networks, especially in comparison to sparsely populated frontier<sup>3</sup> areas in western states. Regional economies differ widely, depending upon many factors, including the absence or presence of strong local employers. The problems confronting the rural South, for example, do not arise out of structural changes in the economic environment (as in the Midwest), but are often the result of chronic problems related to geographic and economic isolation and impoverishment. **This tremendous heterogeneity implies that HCFA must be flexible in both the content and format of messages and in the vehicles used in the dissemination of information about Medicare.**

In 1996, approximately 25 percent (8.25 million) of elderly Medicare beneficiaries lived in non-metropolitan areas (Figure 2.1). In some of these areas, the elderly comprise nearly 20 percent of the rural population, compared to 12 percent of the elderly in the overall U.S. population (Abraham and Neese, 1993). In general, research has shown that individuals living in rural areas are more likely to live below the poverty level, and less likely to have health insurance or Medicaid coverage than individuals residing in urban areas (Abraham and Neese, 1993). **Rural beneficiaries are at risk in many of the same ways as minority elderly, and a communication strategy for reaching them will be characterized by both a diversity of approach and heavy reliance on partnering with local social service organizations and health care providers that have served rural elderly over time.**



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE. Data Source: Medicare Current Beneficiary Survey

<sup>3</sup> Defined as an area with a population density of less than six persons per square mile.



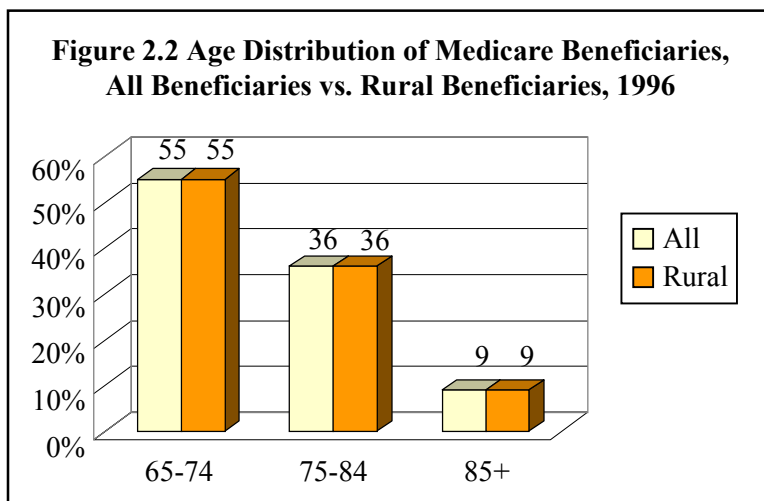
## Key Beneficiary Characteristics

Rural beneficiaries on average differ from the general Medicare population in several important ways:

- ◆ Although their age and gender distributions are very similar to the general Medicare population, rural beneficiaries on average are slightly more likely to live alone, especially in the oldest age category (85 years or older).
- ◆ The rural beneficiary population includes a somewhat smaller proportion of minorities.
- ◆ Rural beneficiaries are more likely to be among the lowest income category and less likely to have completed high school.
- ◆ Rural beneficiaries have moderately less access to some newer forms of communication.
- ◆ Although rural beneficiaries were slightly more likely to report being in fair or poor health and to have more vision and hearing impairments, they were no more likely to report limitations in their activities of daily living.

## Demographic Characteristics

The age distribution of rural beneficiaries is very similar to beneficiaries in general, with the majority of beneficiaries in both groups in the 65 to 74 year old age range (Figure 2.2).



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

The gender makeup of the rural beneficiary population in the aggregate is also very similar to beneficiaries in general, but females in rural areas account for a greater proportion of those 85 years old or older compared with the general elderly Medicare population (Table 2.1).

<b>Table 2.1</b> <b>Gender of Medicare Beneficiaries by Age,</b> <b>All Beneficiaries vs. Rural Beneficiaries, 1996</b>								
<b>Gender</b>	<b>Total Medicare Population</b>		<b>Ages 65 to 74</b>		<b>Ages 75 to 84</b>		<b>Ages 85 and older</b>	
	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>
<i>Male</i>	42.6%	42.1%	46.6%	45.7%	40.2%	39.0%	28.3%	32.6%
<i>Female</i>	57.4%	57.9%	53.4%	54.3%	59.8%	61.0%	71.8%	67.4%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

Living arrangements also change as the rural population ages, similar to the general Medicare population. **Rural beneficiaries are increasingly likely to live alone or with their children as they get older and less likely to live with a spouse (Table 2.2).** As with the general Medicare population, beneficiaries age 85 or older were more than twice as likely to live alone or with their children as those ages 65 to 74.

<b>Table 2.2</b> <b>Living Arrangements of Medicare Beneficiaries by Age,</b> <b>All Beneficiaries vs. Rural Beneficiaries, 1996</b>								
<b>Living Arrangement</b>	<b>Total Medicare Population</b>		<b>Ages 65 to 74</b>		<b>Ages 75 to 84</b>		<b>Ages 85 and older</b>	
	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>
<i>Lives alone</i>	32%	30%	24%	23%	37%	36%	55%	51%
<i>Lives with spouse</i>	57%	56%	66%	65%	51%	50%	23%	24%
<i>Lives with children</i>	8%	9%	6%	7%	8%	9%	15%	17%
<i>Lives with others</i>	4%	5%	4%	5%	4%	5%	7%	8%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

**Rural beneficiaries include a somewhat smaller proportion of minorities compared with the general Medicare population.** The rural beneficiary population is composed of 89 percent non-Hispanic White beneficiaries, a slightly higher percentage than in the general Medicare population (85 percent) (Table 2.3). African-Americans comprise seven percent and Hispanics three percent of the rural population, compared with eight percent and six percent, respectively, of the general beneficiary population.

<b>Table 2.3</b> <b>Race/Ethnicity Distribution of Medicare Beneficiaries by Age,</b> <b>All Beneficiaries vs. Rural Beneficiaries, 1996</b>								
Race/Ethnicity	Total Medicare Population		Ages 65 to 74		Ages 75 to 84		Ages 85 and older	
	Rural	All	Rural	All	Rural	All	Rural	All
<i>White, non-Hispanic</i>	89%	85%	90%	83%	90%	86%	86%	86%
<i>Black, non-Hispanic</i>	7%	8%	6%	8%	7%	7%	9%	8%
<i>Hispanic</i>	3%	6%	3%	7%	3%	5%	4%	5%
<i>Other Race/Ethnicity</i>	1%	2%	1%	2%	1%	2%	1%	1%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

Data Source: Medicare Current Beneficiary Survey

### Economic Characteristics

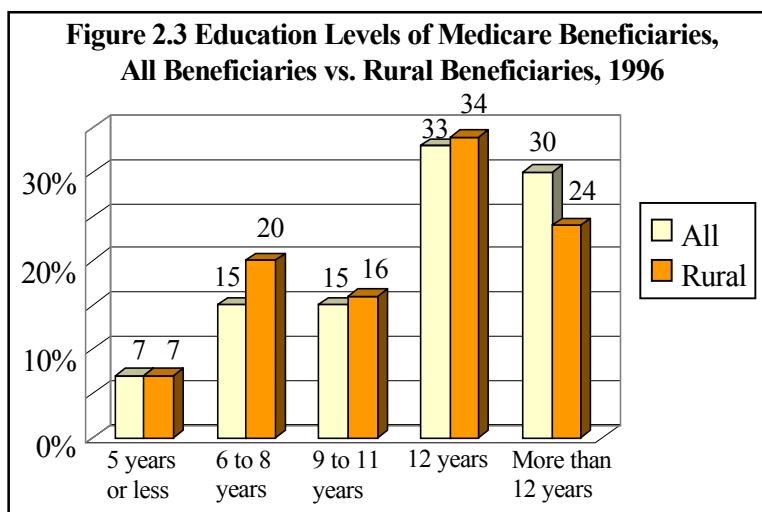
**Compared with the general Medicare population, rural beneficiaries have lower incomes.** As rural beneficiaries age, the difference in income levels from beneficiaries in general becomes even more pronounced (Table 2.4). Approximately 39 percent of rural beneficiaries 65 to 74 years old had an annual income of less than \$15,000, compared with 36 percent of the general Medicare population in this age group. However, this figure increases to 71 percent of rural beneficiaries 85 years and older compared to only 64 percent of the general Medicare population in this age group.

<b>Table 2.4</b> <b>Income Distribution of Medicare Beneficiaries by Age,</b> <b>All Beneficiaries vs. Rural Beneficiaries, 1996</b>								
Annual Income	Total Medicare Population		Ages 65 to 74		Ages 75 to 84		Ages 85 and older	
	Rural	All	Rural	All	Rural	All	Rural	All
<i>Less than \$15,000</i>	47%	42%	39%	36%	53%	45%	71%	64%
<i>\$15,000 - \$30,000</i>	34%	34%	37%	35%	33%	36%	21%	24%
<i>More than \$30,000</i>	19%	24%	24%	29%	14%	19%	8%	12%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

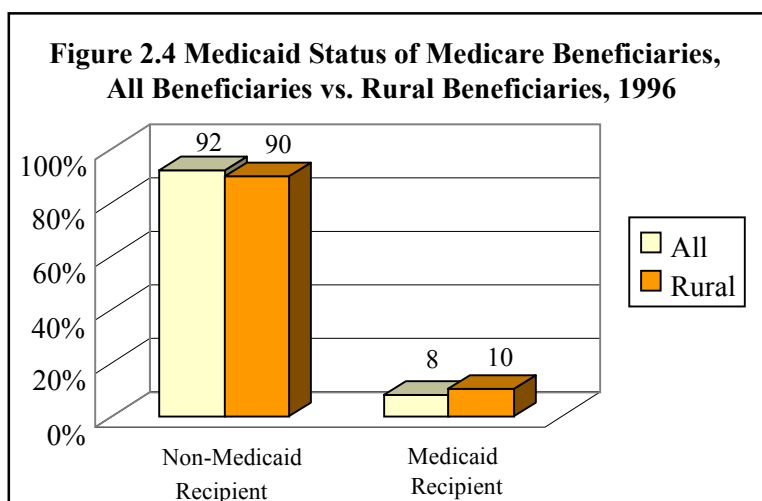
Data Source: Medicare Current Beneficiary Survey

**Rural beneficiaries are, on average, less educated compared with the general Medicare population.** Though nearly the same percentage of each group completed high school, only 24 percent of the rural Medicare population continued beyond high school compared to 30 percent of the general Medicare population (Figure 2.3). As with beneficiaries in general, older rural beneficiaries have less formal education than their younger counterparts. Among rural beneficiaries 85 years or older, 23 percent completed grade 12 compared to 37 percent of those 65 to 74 years old.



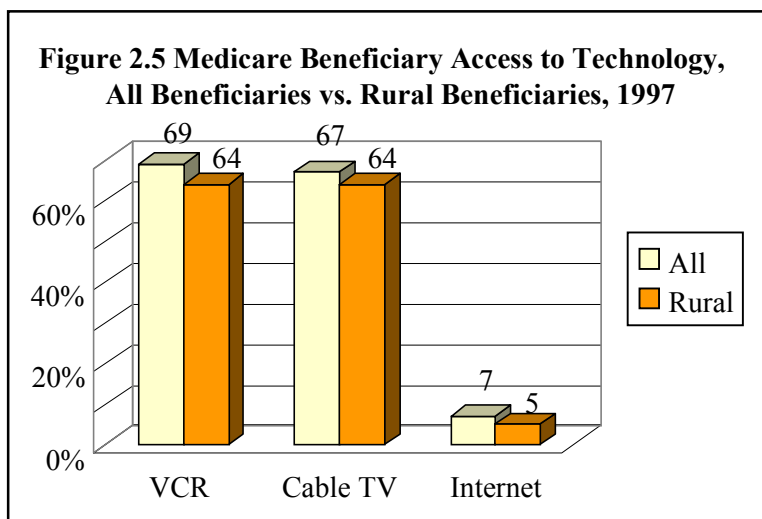
Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

Approximately the same percentage of rural beneficiaries and all beneficiaries were enrolled in Medicaid in 1996. Ten percent of rural beneficiaries received Medicaid assistance compared with eight percent of the overall elderly Medicare population (Figure 2.4).



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

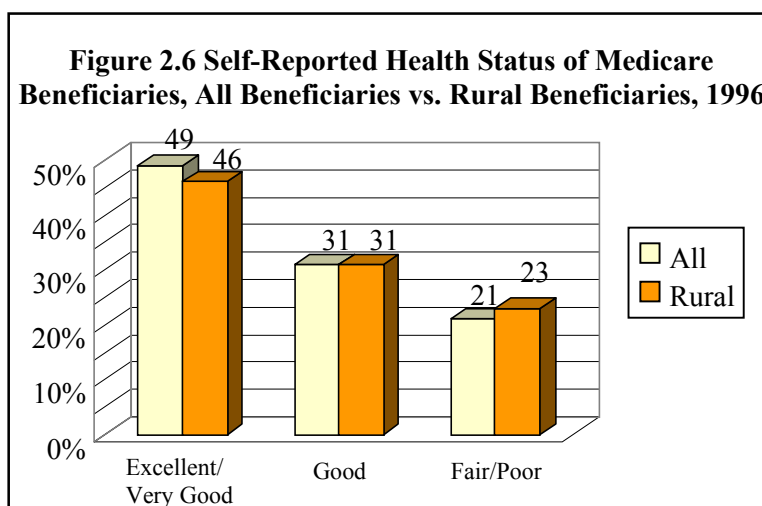
**Access to communication technologies such as VCRs, cable TV, and the Internet is less prevalent among rural beneficiaries than the general Medicare population (Figure 2.5).** The rural population, like other beneficiaries, has considerably more access to VCRs and cable TV than to the Internet. Similar to the general Medicare population, access declines among rural beneficiaries with increasing age.



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

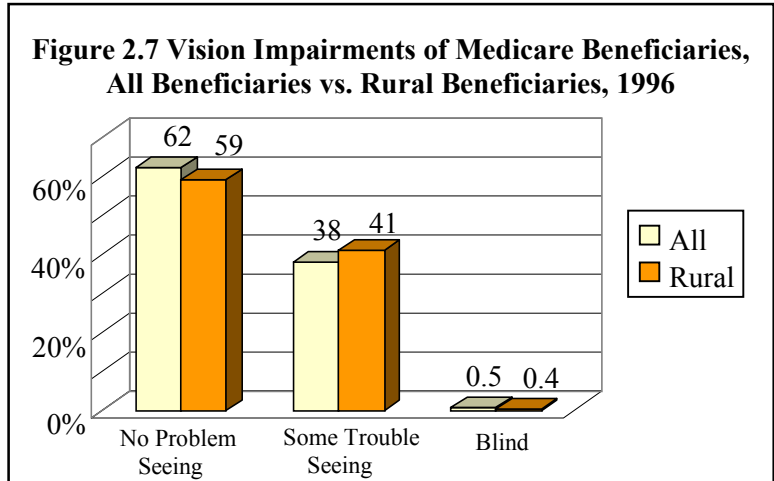
### Health Characteristics

Rurality, defined as “geographic isolation,” has been shown to exert an independent and statistically significant relationship on the likelihood of being in poor health. In 1996, the MCBS data also indicate that rural beneficiaries were somewhat less likely than the general Medicare population to report being in excellent or good health, but the differences are not significant (Figure 2.6). Similar to the general Medicare population, self-reported health status of rural beneficiaries generally declines with age.

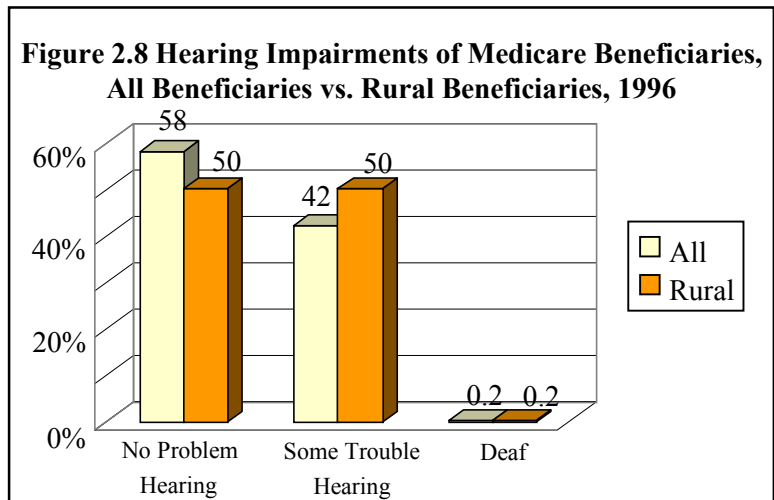


Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

Rural beneficiaries were also more likely than the general Medicare population to report vision and hearing impairments (Figures 2.7 and 2.8). Like the general Medicare population, these impairments become more prevalent with increasing age.



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey



Source: Figure prepared by Barents Group LLC, in collaboration with Project HOPE  
Data Source: Medicare Current Beneficiary Survey

Researchers have found that independent of age, income, and race, living in a rural community is associated with having a greater number of chronic medical conditions (Coward, et al., 1995). Analysis of the MCBS, however, found that rural beneficiaries were no more likely to report difficulties related to Activities of Daily Living (ADLs) than Medicare beneficiaries in general.<sup>4</sup> ADLs are activities related to personal care and include bathing or showering, dressing, getting in and out of bed or a chair, using the toilet, and eating. As they age, beneficiaries have greater trouble performing these activities independently. Nearly 39 percent of rural beneficiaries age 85 or older had difficulty performing one or more ADLs, compared with only 11 percent of rural respondents 65 to 74 years old (Table 2.5).

<sup>4</sup> Using a definition of “rural” as non-MSA counties likely reduces the ability to detect differences between rural and urban beneficiaries. As mentioned in the introduction, rural areas contiguous to urban centers often have relatively high population densities and will differ from rural areas that are farther from urban centers.

<b>Table 2.5</b> <b>Medicare Beneficiary Difficulty Performing ADLs,*</b> <b>All Beneficiaries vs. Rural Beneficiaries, 1996</b>								
ADL Count**	Total Medicare Population		Ages 65 to 74		Ages 75 to 84		Ages 85 and Older	
	Rural	All	Rural	All	Rural	All	Rural	All
0 ADLs	82%	83%	89%	88%	77%	81%	61%	63%
1 ADL	9	8	5	6	12	10	17	15
2 ADLs	4	4	2	2	5	4	9	7
3 ADLs	2	2	2	1	3	3	5	6
4 ADLs	2	2	2	1	2	2	7	6
5 ADLs	1	1	0	1	1	1	1	3

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

Data Source: Medicare Current Beneficiary Survey

\*ADLs=Activities of Daily Living

\*\*ADL Count=Number of ADLs beneficiary has difficulty performing without help.

### Implications for HCFA

The profile of the rural beneficiary population has several implications for designing communication strategies for rural communities across the United States:

- ◆ Rural communities differ in their population density, social service networks, and economies. HCFA should take this heterogeneity into account when designing communication strategies for rural beneficiaries. For example, rural counties that are less isolated may have more access to senior centers, libraries, senior organizations, and other places where they can use some technologies (like the Internet or VCRs) or sources of information. These resources may not be available to more isolated counties.
- ◆ Rural communities are less likely to include minorities than the general Medicare population. Consideration of racial and ethnic differences in designing a strategy, however, may not be as important as other differences among rural areas throughout the country since in the aggregate, at least, racial/ethnic differences between rural and urban areas are not large.
- ◆ Rural beneficiaries are slightly more likely to have lower incomes and lower education, and moderately less access to newer forms of communication such as VCRs, cable TV, and the Internet, compared with beneficiaries in general. This means that, although HCFA may need to rely more on written materials to communicate with rural beneficiaries, these materials must be designed for a slightly less educated population. Simple formats, lower reading levels, and information provided in understandable blocks will increase comprehension among all beneficiaries.

- ◆ Rural beneficiaries report somewhat lower health status compared with the general Medicare population. HCFA should try to promote Medicare knowledge by focusing on health topics of interest to vulnerable beneficiaries, such as vision and hearing care and Medicare coverage of vision- and health-related benefits. Denial of vision and hearing impairments, as well as the social isolation that often characterize the vision- and hearing-impaired populations, impede traditional information delivery methods. Strategies that rely on intergenerational and peer education are particularly effective, as they concurrently develop a support network and also convey information.



### **CHAPTER 3. WHAT INFORMATION DO RURAL BENEFICIARIES WANT OR NEED FROM HCFA?**

This chapter addresses the information needs and knowledge of the Medicare program among rural beneficiaries, highlighting the similarities and differences between these beneficiaries as a group and the general Medicare population. The chapter also examines the information-seeking behavior of rural beneficiaries.

#### **Key Information Needs and Knowledge of Rural Beneficiaries**

**Rural beneficiaries lack basic information about the Medicare program, which is a consistent finding across the inventory, focus groups, and MCBS analyses and is similar to findings for the general Medicare population.**

- ◆ Also like beneficiaries in general, rural beneficiaries may also underestimate the importance of this information, demonstrated by the small percentage who actively searched for Medicare information in 1996 and the large percentages who said they did not need information about MCBS topics and do not keep up with developments in the Medicare program. These numbers suggest that, similar to beneficiaries in general, a majority of rural beneficiaries tend to passively seek information rather than do proactive searching.
- ◆ Like beneficiaries in general, rural beneficiaries are also confused about various Medicare terms and the roles of providers and payers.
  - ◇ In particular, some rural beneficiaries have difficulties understanding their EOMB statement or terms associated with insurance, such as deductible, co-payment, and assignment.
  - ◇ Many do not understand how to identify providers who accept Medicare assignment, their financial obligation in visiting a provider who does not accept assignment, or what they should do when doctors bill for more than Medicare will pay.
  - ◇ Some rural beneficiaries have trouble distinguishing between Medicare Part A and Part B.
  - ◇ Rural focus group participants were also confused about the relationship between Medicare and Social Security, and the roles of different companies in paying their Medicare claims.
- ◆ One key difference between the two groups is that higher proportion of rural beneficiaries than beneficiaries in general reported knowing little or almost none of what they feel they should know about Medicare HMOs.

#### **Information Needs**

Beneficiaries were asked to identify topics in the MCBS that were most important for them to have more information on. As shown in Table 3.1, the top choices for both rural beneficiaries and the general Medicare population – in approximately the same proportions – were the Medicare program itself, staying healthy, and out-of-pocket payment for services.

<b>Table 3.1</b> <b>Information Needs of Rural Medicare Beneficiaries vs.</b> <b>All Medicare Beneficiaries, 1997*</b>		
<b>Medicare Topic</b>	<b>Rural Beneficiaries Citing Topic as Most Important to Have More Information On</b>	<b>All Beneficiaries Citing Topic as Most Important to Have More Information On</b>
<i>Medicare program</i>	41.8%	37.8%
<i>Staying healthy</i>	22.1%	25.8%
<i>Payment for Medicare services</i>	13.7%	14.3%
<i>Medicare HMOs</i>	10.2%	9.4%
<i>Supplemental insurance</i>	6.9%	6.2%
<i>Choosing or finding a doctor</i>	5.3%	6.7%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

Data Source: Medicare Current Beneficiary Survey

\*Percentages are based on the number of beneficiaries who said they needed information about at least one of the topics in the table.

Beneficiaries were also asked how much they feel they know about several Medicare-related topics. **Beneficiaries in rural areas of the country reported varying knowledge levels across Medicare topics, similar to reports from the general Medicare population (Table 3.2).**

<b>Table 3.2</b> <b>Self-Reported Knowledge of Medicare Topics</b> <b>Rural Medicare Beneficiaries vs. All Medicare Beneficiaries, 1997</b>												
<b>Knowledge Level</b>	<b>Medicare Program</b>		<b>Payment for Services</b>		<b>Medigap Policies</b>		<b>HMO Benefits</b>		<b>Finding a Doctor</b>		<b>Staying Healthy</b>	
	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>	<b>All</b>	<b>Rural</b>
<i>Everything/ Most of what I need to know</i>	44%	43%	45%	46%	43%	47%	27%	18%	62%	63%	75%	76%
<i>Some of what I need to know</i>	24%	24%	21%	21%	17%	16%	12%	9%	17%	17%	17%	16%
<i>Little/almost none of what I need to know</i>	32%	33%	34%	34%	41%	37%	61%	74%	21%	21%	8%	8%

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

Data Source: Medicare Current Beneficiary Survey

A slightly higher fraction of rural beneficiaries in the MCBS than beneficiaries in general said they knew most of what they need to about Medigap policies. **However, the focus groups reported that some rural beneficiaries had purchased supplemental policies of questionable worth, highlighting their need for more information on these plans.** In particular, they need simple explanations of Medigap policies, comparative plan information, and premium ranges. This information may be especially important for rural beneficiaries who are more likely to have lower incomes.

Similar to beneficiaries in general, nearly two-thirds of rural beneficiaries felt they had most of the information they needed to locate a doctor (Table 3.2). However, many rural beneficiaries had difficulty combining that knowledge with Medicare requirements. **The focus groups revealed that many rural beneficiaries did not understand how to identify providers who accept Medicare assignment nor their financial obligation in visiting a provider who does not accept assignment.** Moreover, less than one-half of rural beneficiaries said they know everything they feel they should about their financial liability for health services, and ranked more information on this topic as one of their top priorities (Table 3.1).

Like the general Medicare population, the MCBS analysis found that three-fourths of rural beneficiaries felt they have most or all of the information they need about staying healthy (Table 3.2) although they would value additional information (Table 3.1). Beneficiaries who lived in rural areas were *more likely* to be informed about their flu shot benefit and more likely to have received a flu shot, than urban residents. There was no difference between the two groups in their knowledge of the mammogram benefit although a greater percentage of rural beneficiaries received a mammogram, even after controlling for other beneficiary characteristics. HCFA appears to have been relatively successful in reaching the rural population with preventive services information.<sup>5</sup>

**In contrast to the other topics surveyed in the MCBS, the rural population differed markedly from the general Medicare population in self-reported knowledge of Medicare HMOs.** Nearly 74 percent of rural beneficiaries reported knowing little or none of what they need to know about Medicare HMOs. This figure is significantly higher than the 61 percent of the general Medicare population, perhaps because there are fewer HMOs in rural areas than in urban areas. Health insurance options for rural Medicare beneficiaries tend to be more limited than those of their urban counterparts, although this trend may change as managed care plans begin to develop in rural areas (*Managed Care Week*, January 27, 1997). Among Medicare managed care enrollees in 1996, 4.3 percent were from rural areas compared to 95.7 percent from urban areas (MedPAC, 1998). Because of low managed care penetration in rural areas, rural beneficiaries are likely to have much less understanding of how Medicare HMOs operate and how to make a choice among different types of health care plans as they begin to enter rural markets.

### **Beneficiary Information-Seeking Behavior**

While only a small fraction of rural beneficiaries in the MCBS reported needing Medicare information in the past year, approximately 65 to 75 percent of these beneficiaries found the information they needed. **However, nearly one-fourth of those who said they needed information on a specific topic did not obtain answers to their questions either because the source they contacted was not knowledgeable enough or they could not locate a source for**

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<sup>5</sup> In contrast to the general Medicare population, African-American beneficiaries living in rural areas were *more likely* to have received a mammogram than rural White non-Hispanic beneficiaries. In addition, rural beneficiaries with a supplemental private insurance policy were more likely to have received the service than those without a policy. However, older beneficiaries were less likely to have received the procedure than those ages 65 to 74. This finding may correspond to clinical research that shows decreased utility for mammograms among older women.

**the information.** These figures are similar to the general Medicare population in most cases. However, a significantly greater fraction of rural beneficiaries were unable to find a source to provide information on doctors who accept assignment (30 percent vs. 15 percent of the general Medicare population) and on HMOs (13 percent vs. 6 percent of the general Medicare population). **Providing increased access to information on these topics for rural beneficiaries should be a priority for HCFA.**

**Information-seeking strategies reported by rural focus group participants were similar to, and as diverse as, those reported by participants from the general beneficiary population.**

Focus group analysis found that a large portion of rural participants appeared to be proactive information-seekers (beneficiaries who were motivated to anticipate their information needs) and passive information-seekers (beneficiaries who used information that was sent to them but did not explore additional resources). A smaller number seemed to be reactive information-seekers who preferred to receive specific information when needed. There were also several participants who seemed to lack any information-seeking strategy.

Like beneficiaries in general, a very small percentage of rural beneficiaries actively searched for Medicare information in 1996 and large percentages of rural beneficiaries said they did not need information about MCBS topics and do not keep up with developments in the Medicare program. These percentages are essentially the same as those for the general Medicare population. The numbers suggest that, similar to beneficiaries in general, many rural beneficiaries tend to passively or reactively seek information rather than do proactive searching.

### **Implications for HCFA**

- ◆ Rural beneficiaries are very similar to the general Medicare population in the majority of their information needs and understanding of the Medicare program. As a result, HCFA can concentrate on providing additional information on the same topics to rural beneficiaries as for the general Medicare population.
- ◆ As with beneficiaries in general, rural beneficiaries are often confused about the status of their claims and their personal liability for health care expenses. This is a topic that clearly needs more clarification for all beneficiaries.
- ◆ Rural beneficiaries felt they were fairly well informed about how to stay healthy, but were still interested in knowing more about this topic.
- ◆ Rural beneficiaries differ most from general Medicare beneficiaries in their low self-reported knowledge of Medicare HMOs, even though the general Medicare population's knowledge is itself very low. The greater use of preventive services reported by the rural population suggests that this population might be more likely to understand and participate in HMOs because of their emphasis on prevention. As more health plans enter rural markets, HCFA can partner with plans to ensure that beneficiaries get the information they need to make informed choices.

- ◆ Rural beneficiaries also have knowledge gaps about how to identify doctors who accept Medicare assignment. The smaller number of doctors to choose among in rural areas makes it even more imperative that HCFA provide information on how to identify doctors who accept assignment. The Agency can work with local providers to provide lists of doctors in the area who accept assignment. Lists could also be circulated to community groups who work with rural elderly people and to providers themselves for referral information.

## CHAPTER 4. WHAT INFORMATION SOURCES DO RURAL BENEFICIARIES PREFER?

This chapter highlights the differences and similarities of information sources preferred by rural beneficiaries with those preferred by the general Medicare population. Included are discussions of beneficiaries' receipt, use, and evaluation of the Medicare Handbook, preferences for keeping up with Medicare developments, and criteria for evaluating information sources.

### Key Findings on Rural Beneficiaries' Preferred Information Sources

- ◆ Rural beneficiaries are generally similar to the general Medicare population in their choice of preferred information sources, which vary depending on the topic.
- ◆ **The primary difference between rural beneficiaries and beneficiaries in general is the former group's greater reliance on providers as a source of information.** Rural beneficiaries are more likely than the general Medicare population to seek information from providers regarding several topics, such as finding a doctor, staying healthy, out-of-pocket costs, and Medicare-covered services.
- ◆ Like most beneficiaries among those who follow Medicare changes, rural beneficiaries prefer print materials (e.g., the Medicare Handbook, newspapers, and magazines) and a toll-free telephone hotline for keeping up with developments in the Medicare program.
- ◆ Receipt of the Medicare Handbook and use were similar between rural and urban beneficiaries.

### Information Sources

**Much like the general Medicare population, rural beneficiaries turned to different information sources for different topics (Table 4.1).** For example:

- ◆ For information about changes in the Medicare program or for information about out-of-pocket charges, they most frequently used Medicare sources.
- ◆ For information on finding a doctor they can be comfortable with, locating a doctor who accepts Medicare assignment, or staying healthy, rural beneficiaries sought assistance mainly from providers.
- ◆ For information on supplemental policies, many rural beneficiaries relied on insurance companies.

Both rural and general Medicare beneficiaries identified the same sources in the same proportion, with the exception of finding information on HMOs (Table 4.1). **The general Medicare population was more likely to have contacted an insurance company (including HMOs) for Medicare information than rural beneficiaries** probably because there is less access to HMOs in rural areas.

<b>Table 4.1</b> <b>Preferred Information Sources for Rural Medicare Beneficiaries vs.</b> <b>All Medicare Beneficiaries, 1997*</b>							
<b>Medicare Topic</b>	<b>Medicare /Carrier/ 1-800</b>	<b>Doctor/ provider</b>	<b>Community Org.</b>	<b>Family, Friends</b>	<b>Insurance Company</b>	<b>AARP/Sr. Citizens' Group</b>	<b>Other</b>
Medicare program							
<i>Rural Beneficiaries</i>	57.6	25.2	8.3	3.4	3.0	8.2	0.4
<i>All Beneficiaries</i>	53.8	22.3	8.3	4.6	2.9	7.7	0.3
Out-of-pocket payments							
<i>Rural Beneficiaries</i>	62.4	23.3	4.1	2.9	5.0	2.1	0.2
<i>All Beneficiaries</i>	64.3	20.7	4.4	2.6	5.5	2.1	0.4
Supplemental insurance							
<i>Rural Beneficiaries</i>	19.1	10.5	7.0	6.6	44.9	11.2	0.8
<i>All Beneficiaries</i>	19.8	11.6	7.3	6.5	42.5	11.0	1.5
Medicare HMOs							
<i>Rural Beneficiaries</i>	50.6	17.1	8.0	6.5	10.5	6.9	0.4
<i>All Beneficiaries</i>	40.4	18.6	9.5	7.7	15.5	7.6	0.7
Finding a doctor							
<i>Rural Beneficiaries</i>	11.9	47.6	6.0	29.5	1.8	1.6	1.0
<i>All Beneficiaries</i>	12.6	47.3	6.0	26.5	4.7	2.2	0.8
Staying healthy							
<i>Rural Beneficiaries</i>	5.4	64.5	11.6	10.2	1.5	4.8	2.0
<i>All Beneficiaries</i>	6.6	64.7	10.3	9.6	3.1	3.8	2.0

Source: Table prepared by Barents Group LLC, in collaboration with Project HOPE

Data Source: Medicare Current Beneficiary Survey

\*Percentages are based on respondents who chose at least one source. Respondents who said they did not need information on the topic are excluded from the figures in the table.

**In contrast to the general Medicare population, rural beneficiaries were somewhat more likely to rely on their health care providers as sources of Medicare information:**

- ◆ Proportionally more rural beneficiaries relied on providers for information on out-of-pocket costs for specific services during the past year.
- ◆ Rural beneficiaries also were more likely to consult providers about services covered by Medicare. The general Medicare population was more likely to seek this information from Medicare sources.

The inventory research also found that health care providers are considered to be the most trusted source of information in rural communities. In rural communities, beneficiaries' relationships with providers are often long term and somewhat more stable than the relationships in urban settings. Additionally, providers reported that one-on-one interpersonal channels were most

effective with rural beneficiaries because they were able to use local idiom and metaphors to illustrate their points.

**Groups representing senior citizens, like AARP, are valued about equally as sources of information by rural beneficiaries and the general Medicare population.** The MCBS analysis found that beneficiaries living in rural areas were slightly more likely than the general Medicare population to prefer senior citizens' groups, such as the AARP, as a source of information for Medicare-related topics. However, rural focus group participants said they rely less frequently on AARP than participants from other beneficiary subgroups, although many still found it an important source of information about Medicare.

**Among rural beneficiaries, the most common sources used to acquire general information about the Medicare program were television, newspapers, radio, magazines, and Medicare publications.** These sources are similar to those identified by the general Medicare population. They also depended on family and friends, their local Social Security office or Medicare office (including the telephone hotline), and their doctor to answer questions about Medicare. These sources are generally places where the beneficiary obtains information on a one-on-one basis.

#### Medicare Handbook

- ◆ Of rural beneficiaries who said they keep up with changes in the Medicare program, nearly one-half (49 percent) prefers to use the annual, updated edition of the Medicare Handbook.<sup>6</sup>
- ◆ Beneficiaries who live in rural areas were slightly more likely to have reported they received the Medicare Handbook than those living in urban areas.
- ◆ Rural beneficiaries also reported slightly greater use of the Handbook than beneficiaries in urban areas.
- ◆ Of all beneficiaries who had referenced the Handbook, an overwhelming majority (95 percent) reported that the Handbook was a useful document, with 40 percent reporting it to be very useful. However, it could not be determined whether rural beneficiaries found it more useful than the general Medicare population because there were too few observations to establish statistical significance.
- ◆ Rural focus group participants generally agreed that the Medicare Handbook is easy to understand, though a few had complaints about its language and organization. This is consistent with findings from the inventory research, which indicated that seniors living in rural areas often have trouble understanding basic information about Medicare.
- ◆ Rural focus group participants who said they had a copy reported using it to look up questions about which medical procedures are covered or whether to choose an HMO. Some participants reported that they read through the entire book when they first enrolled in Medicare.

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<sup>6</sup> Media sources were preferred by 36 percent of rural beneficiaries. About one-quarter of survey respondents also said they prefer to use a toll-free number to track developments in Medicare. Very few beneficiaries cited on-line computer access as a preferred source. These preferred sources are nearly identical to those identified by the general Medicare population.



## Criteria for Evaluating Information Sources

Trustworthiness was the single most valued factor in determining a source's usefulness – a criterion identified by both the rural and general Medicare populations.

- ◆ **Both rural and general beneficiary focus group participants rated HCFA and Medicare contractors high on trustworthiness for information and on amount of information**, as the agencies responsible for Medicare administration. Beneficiaries residing in rural areas generally ranked official bureaucratic sources highly, and they also ranked medical providers high for amount of information and trust.
- ◆ Rural focus group participants were more cautious in their assessment of the media's ability to provide unbiased and accurate information than the general beneficiary population. The view of rural beneficiaries was that information from mass media sources is often contradictory and not to be trusted.
- ◆ In contrast to general beneficiary participants, rural beneficiaries ranked supplemental insurers low on trust. This difference may be related to rural beneficiaries' value for personal privacy and their suspicion of commercial endeavors.
- ◆ Rural residents ranked community sources somewhat lower than did general beneficiary participants, both in terms of amount of information and in terms of trust. Again, privacy was an issue for rural residents. They may also have less access to some kinds of community resources than people living in more heavily populated areas.
- ◆ Focus group participants from rural areas ranked family and friends much lower on amount of information received than did participants from the general Medicare population. Rural beneficiaries also ranked friends and family somewhat lower in trust. Rural residents may be more isolated from family and friends, but the discussions also showed a strong sense of self-sufficiency and personal privacy.

## Implications for HCFA

- ◆ Both the rural subgroup and general Medicare population generally use the same sources to locate information across a number of Medicare-related topics. Rural beneficiaries differ from the general Medicare population, however, in their stronger reliance on health care providers for Medicare information. HCFA can exploit this reliance by partnering with rural providers to disseminate information. Rural health clinics, primarily staffed by nurse practitioners and physician assistants, are particularly well suited to serving the health care and information needs of the rural elderly, especially when they are able to provide transportation.
- ◆ Groups representing senior citizens can be valued sources of information on Medicare policies and supplemental insurance for rural beneficiaries. As problems with purchases of relatively useless supplementary policies was reported by the rural population, HCFA may choose to use senior citizen groups to provide impartial information regarding insurance. Senior organizations need to be able to get accurate information from HCFA in order to increase their trust as a source. The inventory research also found that local community health agencies could be an important source of information to rural beneficiaries. These

agencies need to have access to accurate and current Medicare program information to fulfill this role.

- ◆ An important criterion for evaluating an information source is trustworthiness, a finding common to both the rural subgroup and general beneficiary populations. Since rural beneficiaries see HCFA as trustworthy, it may be advisable to put HCFA's name clearly and in large type on all communication materials.
- ◆ Many rural beneficiaries depend on updated versions of the Medicare Handbook for current information. HCFA can ensure its continued usefulness to this population – some of who may be very isolated and have few alternatives – by adding information (e.g., on managed care plans available in the area, as is planned) while continuing to structure Handbook material in a way that is easy to use and understand.

## CHAPTER 5. WHAT COMMUNICATION MODES DO RURAL BENEFICIARIES PREFER?

This chapter highlights how rural beneficiaries prefer to obtain Medicare and health-related information, comparing their preferences with those of the general Medicare population. The chapter also examines rural beneficiaries' access to some relatively new communication technologies that HCFA is considering using more heavily to communicate with all beneficiaries.

Medicare beneficiaries get information about the Medicare program and their health care through a variety of interactive and non-interactive communication vehicles. In fact, their use of a particular communication tool appears to coincide with their particular information needs at the time. Questions on broad topics – the Medicare program in general and information about staying healthy – are often answered via non-interactive tools such as pamphlets and brochures, radio and television, or magazines and newspapers. Answers to more specific and immediate questions are more frequently sought through interactive formats, such as live telephone or face-to-face conversations.

### Key Findings on Rural Beneficiaries' Preferred Communication Modes

- ◆ **Among interactive communication modes, as with beneficiaries in general, rural beneficiaries demonstrated an overwhelming preference for in-person formats.**
- ◆ It is unclear whether rural beneficiaries are more or less likely to use the telephone to gather information than the general Medicare population based on inconsistencies between focus group and MCBS findings.
- ◆ **Among non-interactive tools, both rural and general Medicare beneficiaries strongly preferred brochures and other written material for ease in reviewing information.**
- ◆ General Medicare focus group participants were suspicious of commercial interests and sensationalism among media sources; however, rural participants were more concerned about not being able to refer back to information on the television and the ability of the media to meet specific information needs.
- ◆ Few rural beneficiaries have access to computers or the Internet and few prefer this technology for obtaining Medicare-related information.

### Communication Modes

#### Interactive Communication Tools

*In-person Contact.* As with beneficiaries in general, the market research found that **rural beneficiaries most prefer in-person contact for obtaining information on a variety of Medicare topics (although in slightly higher percentages than beneficiaries in general).** Rural focus group participants emphasized that talking in-person to someone knowledgeable gives them an opportunity to assess their trustworthiness. In addition, many rural beneficiaries expressed a preference for face-to-face contact with their physician. Over three-fourths of MCBS

rural respondents preferred an in-person discussion for finding a doctor (76 percent), which is higher than beneficiaries in general (70 percent).

The inventory research found that rural beneficiaries prefer in-person contact through such sources as physicians, friends, neighbors, and relatives. **Health care providers are considered to be the most trusted source of information in rural communities.** Beneficiaries' relationships with providers are often long term and somewhat more stable than the relationships observed in urban settings. Additionally, providers reported that one-to-one interpersonal channels were most effective with rural beneficiaries, because they were able to use local idiom and metaphors to illustrate their points. **The implication for HCFA is to strengthen its communication with rural providers and ensure that providers have the information they need to accurately answer beneficiaries' questions.**

*Telephones.* **Rural focus group participants said they rely more often on the telephone as a way to get information than other beneficiaries. In contrast, MCBS respondents said they rely less on telephone information than other beneficiaries.** The inconsistency in findings may relate the degree of "ruralness" of focus group participants compared with MCBS respondents, with rural focus group participants more likely to be from more isolated and less sparsely populated rural areas. The focus groups found that many rural beneficiaries, like the general Medicare population, were vocal in their dislike of automated telephone systems. Complaints centered on the length of menus and confusing or unclear choices not pertinent to their problems. Rural participants differed from the general Medicare population in their tolerance for waiting. Rural beneficiaries expressed less concern about long waiting times, focusing instead on accurate rather than prompt responses. Rural participants favored a limit on waits of five to ten minutes and a limit on automated menus of three to five options.

#### Non-Interactive Communication Tools

*Print Materials.* **Similar to beneficiaries in general, brochures and other written materials were strongly preferred methods for relaying information to rural beneficiaries.** These materials permit self-paced review and referencing. Despite general enthusiasm for written materials, some rural focus group participants reported difficulty understanding information presented in this format. Rural focus group participants also expressed irritation with mailed notices. They reported receiving large amounts of junk mail and many said they often throw mail notices out without looking at them. **Apparently the mail system is not the best way to get written materials to rural beneficiaries.** If information is mailed, the sending agency should be clearly visible on the outer envelope.

*Radios, Television, and Videos.* A small fraction (less than 10 percent) of rural MCBS respondents indicated they used television, newspapers, radio, or magazines to obtain information about the Medicare program, slightly more than among general Medicare respondents. However, about 15 percent of both populations relied on television and videos for information on staying healthy. A few rural focus group participants reported watching television programs about medical issues. Most complained about radio and television, but not always for the same reasons as general beneficiaries. General Medicare participants were suspicious of commercial interests and sensationalism. Rural participants, however, were more concerned

about not being able to refer back to information heard on television and that the general nature of televised information may not be applicable to their specific situation.

The inventory research found that targeted television and radio media campaigns are more difficult in rural areas than in urban areas, but advances in communication technology, such as direct broadcast satellite television (DBS), may help bridge this gap in upcoming years. Five ingredients were generally recommended by respondents for a successful effort to provide information to rural beneficiaries:

- ◆ Thoughtful evaluation of available media,
- ◆ Creative application of media,
- ◆ Careful study and specification of target audiences,
- ◆ Messages that build on the audience's current knowledge, and
- ◆ Pretesting messages and careful evaluation of results.

There was very little discussion about videotapes in rural focus groups. Few rural participants reported personal experiences with videotapes as sources of information about health care. A small number of participants criticized videotapes as a medium, mentioning timeliness and cost, among other things.

*Computers and the Internet.* The inventory research found that interactive television and computer networks are among the new media being used to bring health information and health care to rural communities. The costs of providing rural healthcare through telemedicine systems have declined, and as of 1992, as many as 25 states had or were planning such systems. The literature contains several examples of the successful use of these technologies.

However, like beneficiaries in general, rural participants reported mildly negative attitudes towards computers as an information source. Few endorsed the idea wholeheartedly. Instead, participants raised concerns about security and timeliness of computerized information. In addition, one respondent found computers too impersonal. A few rural participants thought computers could be useful for some specific purposes, such as for reviewing medical bills or comparing supplemental insurers. In addition, Chapter 2 indicates that only 5 percent of rural beneficiaries said they had Internet access. Internet seems like a very promising technology for providing information to isolated rural communities, but at this time is not too useful for the current generation of beneficiaries.

### **Implications for HCFA**

- ◆ Rural beneficiaries demonstrated an overwhelming preference for receiving information in-person. As suggested in the previous chapter, HCFA can partner more closely with health care providers, community health centers, SHIPs, and local senior citizen organizations in rural areas to foster interpersonal communications.
- ◆ Telephone hotlines staffed by accurate and knowledgeable representatives may be helpful in reaching rural beneficiaries, who appear to be more tolerant of waiting times than the general Medicare population.

- ◆ With non-interactive tools, both rural and general beneficiaries preferred brochures for ease in reviewing information. This method also addresses rural beneficiaries' concerns for self-paced review and referencing. However, print materials need to be designed for easy use by those with low literacy levels and vision and hearing impairments.
- ◆ Cable television and VCRs may be good communication formats for rural beneficiaries since these beneficiaries are likely to have fairly good access to such technologies. However, few rural participants reported personal experiences with videotapes as sources of information about health care. Television and radio campaigns need to be designed with the unique characteristics of rural beneficiaries in mind.
- ◆ Fewer rural beneficiaries compared with beneficiaries in general reported having access to computers or the Internet or felt comfortable using these technologies. This suggests that this tool's usefulness for disseminating Medicare information at this time is very limited for the rural population but may hold promise for the future.

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